the left at three; the tongue was protruded straight, and the facial muscles were not involved; muscular power of hands apparently the same. Two days later still, the right arm was found to be less powerful than the left. The symptoms indicated a cortical cerebral lesion, affecting the middle frontal convolution—which lay beneath the site of the original injury—and extending upward and backward, gradually involving the ascending frontal convolution; the lesion seemed thus circumscribed, because if it involved the inferior frontal convolution, aphasic symptoms would have been present. In view of the fact that the patient presented chilly sensations every morning, that the wound had been somewhat septic in character, and that the development of the hemiplegia was slow and late, it seemed probable that septic matter had been absorbed and an internal purulent inflammation developed. After proper preparation then, an incision was made through the frontal scalp, and a button of bone removed, hæmorrhage from a small branch of the meningeal artery being controlled by hot water. No intra-cranial fracture of the bone was found, but the dura mater was dark and had no communicated pulsation from the brain. Dark brown blood, but no pus, was brought out through the needle of a hypodermic syringe, and the matter continued to be ejected from the puncture when the needle was withdrawn; assisted by the pulsations of the brain, this continued when the opening was slightly enlarged, until almost all the fluid was evacuated. Drainage was then secured by disinfected horse hair, the wound dressed antiseptically, and the patient passed on to a perfect recovery.—*Jour. Am. Med. Assn.*, June 18, 1887.

II. Operative Relief of the Deformity Termed "Pug Nose." By JOHN O. ROE, M. D. (Rochester, N. Y.). Recognizing that this deformity is due to the disproportionate size of the end of the nose, the author brings it into symmetrical proportion with the bridge by the following operation. After deadening the sensibility of the interior of the end of the nose by cocaine, general anæsthesia being unnecessary, and brightly illuminating the part, the end of the nose is turned upward and backward and held with a retractor by an assistant, while sufficient of the superfluous tissue is removed or dissected

out to allow the nose to conform to the desired shape. If the tissue is to be removed from that portion where the mucous membrane is not too firmly adherent, the membrane should be dissected back to be replaced after the operation. In some cases, no after-treatment is required, but in others it is advisable to mould a saddle or splint to the top of the nose, so as to make it assume the desired form while healing. Where the deformity is due to a malformation of the cartilages of the ala bulging outward with a corresponding concavity on the inside, the nose can readily be moulded into a handsome shape by cutting, with a tenotomy knife, through these cartilages in different places, sufficient to destroy their elasticity; then by inserting a silver or hard rubber tube of the proper size and shape into the nostril, and conforming the saddle to the outside of the nose, it is encased in an inside and outside splint that compel it to conform to the exact shape desired. The author has operated in five cases with uniformly excellent results.—*N. Y. Med. Rec.*, June 4, 1887.

III. A Consideration of the Results in Three Hundred and Twenty-seven Cases of Tracheotomy, Performed at the Boston City Hospital from 1864 to 1887. Drs. R. W. Lovett and John C. Munro, in the July number of *The American Journal of the Medical Sciences*, present an elaborate detailed study of the results of tracheotomy at the Boston City Hospital. They show that the results of operation in the series of cases studied are above the average in spite of the predominance of bad cases. They show that young children are especially liable to have extension of the diphtheritic process to the bronchi and lungs; in fact, that the chances are three to one that if they die they will die of suffocation. That, in Boston, tracheotomy at the hospital is most fatal at those times when diphtheria is most fatal in the whole city, and incidentally that the mortality per cent. from croup and diphtheria in the whole city vary by the month in unison. That cases with membrane in the pharynx at the time of operation are more likely to die than those where it is not present. That the mortality per cent. after tracheotomy rises steadily as the operation is done on the first, second, third or fourth day of the difficult breathing. That nasal discharge, albuminuria, and enlarge-